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ANNUAL COST REPORT -- SCHEDULE D-4 -- CAPITAL COSTS

VENDOR NAME_____ VENDOR NUMBER_____ FYE_____

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Alloca. of Costs	(8) Non-Certified & Non-Nursing Fac. Alloca. of Costs	(9) Ancillary Hospital-Based Facility Only
1	Depreciation-Building								
2	Depreciation-Equipment								
3	Interest Expense-Capital Related								
4	Rent								
5	Land Improvements								
6	Leasehold Improvements								
7	Amortization of Start-up Costs								
8	Other Capital Costs_____								
9	Other Capital Costs_____								
10	Other Capital Costs_____								
11	Other Capital Costs_____								
12	Other Capital Costs_____								
13	Other Capital Costs_____								
14	Other Capital Costs_____								
15	Other Capital Costs_____								
16	Other Capital Costs_____								
17	Other Capital Costs_____								
18	Other Capital Costs_____								
19	Other Capital Costs_____								
20	Other Capital Costs_____								
21	Other Capital Costs_____								
22	Other Capital Costs_____								
23	*Total*								

	Grand Totals	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
24	Totals of Schedules D-1 through D-4								
25	Total of Schedule D-5, Column 8								
26	Total Routine CNF Cost								
27	Totals from Schedule D-5								
28	Total Cost								

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ANNUAL COST REPORT -- SCHEDULE D-5 -- ANCILLARY COSTS

PAGE 1

VENDOR NAME_____ VENDOR NUMBER_____ FYE_____

(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Costs	(7) Indirect Costs	(8) CNF Indirect Costs
Physical Therapy							
1 Physical Therapist Salaries							
2 Physical Therapist Assistants Salaries							
3 Physical Therapist Aides Salaries							
4 Other Salaries							
5 *Subtotal-Salaries*							
6 Employee Benefits Reclassification							
7 Contracted Services							
8 Equipment Depreciation							
9 Other Expenses_____							
10 Other Expenses_____							
11 Hospital-Based Indirect Ancillary							
12 *Total*	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 3, Col. 4)						
X-Ray							
13 Professional Salaries							
14 Other Salaries							
15 *Subtotal-Salaries*							
16 Employee Benefits Reclassification							
17 Supplies							
18 Equipment Depreciation							
19 Other Expenses_____							
20 Hospital-Based Indirect Ancillary							
21 *Total*	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 4, Col. 4)						
Laboratory							
22 Professional Salaries							
23 Other Salaries							
24 *Subtotal-Salaries*							
25 Employee Benefits Reclassification							
26 Supplies							
27 Equipment Depreciation							
28 Other Expenses_____							
29 Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 5, Col. 4)						

Attachment 4.19-D, Exhibit B

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Attachment 4.19-D, Exhibit B

ANNUAL COST REPORT -- SCHEDULE D-5 -- ANCILLARY COSTS

VENDOR NAME_____ VENDOR NUMBER_____ FYE_____

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Costs	(7) Indirect Costs	(8) CNF Indirect Costs
	Oxygen/Respiratory Therapy							
31	Respiratory Therapist Salaries							
32	Respiratory Therapist Assistants Salaries							
33	Respiratory Therapist Aides Salaries							
34	Other Salaries							
35	*Subtotal-Salaries*							
36	Employee Benefits Reclassification							
37	Supplies							
38	Equipment Depreciation							
39	Other Expenses_____							
40	Other Expenses_____							
41	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 6, Col. 4)						
42	*Total*							
	Speech							
43	Professional Salaries							
44	Other Salaries							
45	*Subtotal-Salaries*							
46	Employee Benefits Reclassification							
47	Equipment Depreciation							
48	Other Expenses_____							
49	Other Expenses_____							
50	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 7, Col. 4)						
51	*Total*							
	Other							
52	Professional Salaries							
53	Other Salaries							
54	*Subtotal-Salaries*							
55	Employee Benefits Reclassification							
56	Equipment Depreciation							
57	Other Expenses_____							
58	Other Expenses_____							
59	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 8, Col. 4)						
60	*Total*							

ANNUAL COST REPORT — SCHEDULE D-5 — ANCILLARY COSTS

VENDOR NAME_____ VENDOR NUMBER_____ FYE_____

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Costs	(7) Indirect Costs	(8) CNF Indirect Costs
	Drugs							
56	Pharmicist Salaries							
57	Other Salaries							
58	*Subtotal-Salaries*							
59	Employee Benefits Reclassification							
60	Drugs							
61	Equipment Depreciation							
62	Other Expenses_____							
63	Other Expenses_____							
64	Other Expenses_____							
65	Other Expenses_____							
66	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9, X Sch. F, Section B, Line 9, Col. 4)						
67	*Total*							

ANNUAL COST REPORT—SCHEDULE D-6—RECLASSIFICATIONS OF EXPENSES

VENDOR NAME_____ FYE_____

VENDOR NUMBER_____

Line	(1) Explanation	(2) Increase Amount	(3) Decrease Amount	(4) Cost Center Affected
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
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57				
58				
59				
60				
61	*Total*			

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ANNUAL COST REPORT—SCHEDULE D-7—ADJUSTMENTS TO EXPENSE

VENDOR NAME_____ FYE_____

VENDOR NUMBER_____

Line	(1) Explanation	(2) * Basis for Adjustment (A) or (B)	(3) Amount	(4) Sch. & Line # Affected
1	Laundry & Linen			
2	Employee & Guest Meals			
3	Gift, Flower & Coffee Shop			
4	Grants, Gifts & Income Designated by the donor for a specific purpose			
5	Beauty & Barber Shop **			
6	Excess Owners Compensation			
7	Telephone Serv.(Pay Serv. Excluded)			
8	Radio & Television Service			
9	Vending Machine Commission			
10	Sale of Drugs to other than Patients			
11	Sale of Medical & Surgical Supplies to other than Patients			
12	Sale of Medical Record & Abstracts			
13	Sale of Scrap, Waste, Etc.			
14	Rental of Quarters to Employees & Others			
15	Rental of Facility Space			
16	Trade, Quantity, Time & Other Discounts			
17	Rebates & Refunds of Expenses			
18	Interest Not Allowed			
19	Recovery of Insured Loss			
20	Depreciation			
21	Gain or Loss on Disposition of Assets			
22				
23				
24				
25				
26				
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41				
42				
43				
44				
45				
46				
47				
48				
49				
50				
51				
52				
53	*Total*			

* (A) COST (B) REVENUE

** *Beauty & Barber Shop Revenues in excess of Beauty & Barber Shop supply & personnel cost is to be adjusted in an Administrative &*

ANNUAL COST REPORT -- SCHEDULE E -- ANCILLARY SETTLEMENT

VENDOR NAME_____ VENDOR NUMBER_____ FYE_____

(1)	(2) Direct (From Sch. D-5, Col. 6)	(3) Medicaid Direct	(4) Medicaid Payments	(5) Receivable From KMAP (Payable To KMAP)
1 Physical Therapy				
2 X-Ray				
3 Laboratory				
4 Oxygen/Respiratory Therapy				
5 Speech				
6 Other				
7 Drugs				
8 *Total*				

ANNUAL COST REPORT—SCHEDULE F—ALLOCATION STATISTICS

VENDOR NAME _____ FYE _____

VENDOR NUMBER _____

A. NURSING SALARIES

1. CERTIFIED NURSING FACILITY _____
2. OTHER _____
3. CERT. NURSING FAC. PERCENTAGE _____%

ALLOCATION METHOD:

PATIENT DAYS ____ VALID TIME STUDY ____

DIRECT COST ____ DIRECT HOURS ____

OTHER APPROVED METHOD ____

B. SQUARE FOOTAGE

	(1) SQ. FT.	(2) PERCENT	(3) HOSPITAL-BASED SQ. FT.	(4) HOSPITAL-BASED PERCENT
1. CERT. NURSING FACILITY				
2. OTHER				
3. PHYSICAL THERAPY *				
4. X-RAY *				
5. LABORATORY *				
6. OXYGEN/RESP. THERAPY *				
7. SPEECH *				
8. OTHER *				
9. DRUGS *				
10. TOTAL				

* For Hospital-Based Certified Nursing Facility Only

C. DIETARY

	(1) MEALS	(2) PERCENT
1. CERT. NURSING FACILITY		
2. ALL OTHER		
3. TOTAL		

ALLOCATION METHOD:

MEAL COUNT ____ 3 x INPATIENT DAYS ____

D. ANCILLARY CHARGES

	(1) TOTAL	(2) CNF	(3) CNF %	(4) MEDICAID	(5) MEDICAID
1. PHYSICAL THERAPY					
2. X-RAY					
3. LABORATORY					
4. OXYGEN/RESP. THERAPY					
5. SPEECH					
6. OTHER					
7. DRUGS					
8. TOTAL					

E. OCCUPANCY STATISTICS

	(1) CERTIFIED NURSING FACILITY	(2) OTHER LONG-TERM CARE	(3) ACUTE CARE
1. LICENSED BEDS AT BEGINNING OF PERIOD			
2. LICENSED BEDS AT END OF PERIOD			
3. BED DAYS AVAILABLE			
4. TOTAL PATIENT DAYS			
5. % OCCUPANCY			
6. Medicaid PATIENT DAYS			
7. % Medicaid OCCUPANCY			

F. ADDITIONAL STATISTICS

1. DIRECT ROUTINE NURSING HOURS - CERTIFIED NURSING FACILITY ONLY	
2. TOTAL DIRECT DIETARY HOURS	
3. TOTAL DIRECT HOUSEKEEPING HOURS	

NURSING FACILITY

SCHEDULE J-TAX

For the Month of _____ 1993

Provider Name _____

Provider Number _____

	Revenue	Tax
Certified NF Beds*	_____	_____
All Other Taxed Beds*	_____	_____
Total Per Provider Tax Forms Submitted To Revenue Cabinet	_____	_____

*Revenue and Tax must be directly costed to certified NF beds. Revenue and Tax must include amounts for ancillaries.

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COMPUTATION OF DUAL LICENSED ANCILLARY COST

HOSPITAL _____ ICF DUAL LICENSED PROVIDER NUMBER _____

VENDOR NUMBER _____ SNF DUAL LICENSED PROVIDER NUMBER _____

ANCILLARY COST CENTERS	TOTAL ANC. COST COL. 1	TOTAL DIRECT COST COL. 2	DIRECT COST % COL.3 (2/1)	TOTAL INDIR. COST COL. 4	INDIR. COST % COL. 5 (4/1)	RATIO OF COST TO CHG COL.6	DIRECT COST TO CHG RATIO COL. 7 (6X3)	MEDICAID DUAL INPATIENT CHARGES (BILLED) COL. 8	INPATIENT DIRECT COST COL. 9 (7X8)	INDIRECT COST TO CHG. RATIO COL. 10 (6 X 5)	MEDICAID DUAL CHARGE (BILLABLE & NON-BILLABLE UNDER SNF) COL. 11	INPATIENT INDIRECT COST COL. 12 (10 X 11)
41 RADIOLOGY-DIAGNOSTIC												
42 RADIOLOGY-THERAPEUTIC												
43 RADIOISOTOPE												
44 LABORATORY												
45 PBP CLINIC LAB SVC-PRG. ONLY												
46 WHOLE BL. & PK. RED BL. CELLS												
48 IV THERAPY												
49 RESPIRATORY THERAPY												
50 PHYSICAL THERAPY												
51 OCCUPATIONAL THERAPY												
52 SPEECH PATHOLOGY												
53 ELECTROCARDIOLOGY												
54 ELECTROENCEPHALOGRAPHY												
55 MED. SUPPLIES CHG. TO PT.												
56 * DRUGS CHARGED TO PATIENTS												
101 TOTAL												

104 AMOUNT RECEIVED FROM THE MEDICAID PROGRAM (FROM PROGRAM PAID CLAIMS LISTING) _____

105. AMOUNT DUE PROGRAM/PROVIDER (LINE 101, COL. 9 LESS LINE 104) _____

INSTRUCTIONS

1. TOTAL ANCILLARY COSTS FROM HCFA-2552-92, WORKSHEET C, COLUMN 3
2. ALL COST ALLOWABLE UNDER MEDICAID IC/SNF RULES AS DIRECT COST
3. COLUMN 2 DIVIDED BY COLUMN 1
4. ALL OTHER ANCILLARY COST (COLUMN 1 LESS COLUMN 2)
5. COLUMN 4 DIVIDED BY COLUMN 1
6. RATIO OF COST TO CHARGES FROM HCFA-2552-92, WORKSHEET C, COL. 8
7. COLUMN 6 MULTIPLIED BY COLUMN 3
8. DUAL LICENSED CHARGES BILLED TO THE MEDICAID PROGRAM
9. COLUMN 7 MULTIPLIED BY COLUMN 8
10. COLUMN 6 MULTIPLIED BY COLUMN 5
11. ALL DUAL LICENSE CHARGES INCLUDING THOSE CHARGES BILLABLE AND NON-BILLABLE TO THE MEDICAID IC/SNF PROGRAM. SHOULD NOT INCLUDE THOSE CHARGES CONSIDERED TO BE NON-ALLOWABLE COST FOR SERVICES IN A LONG TERM CARE SETTING
12. COLUMN 10 MULTIPLIED BY COLUMN 11. TRANSFER THIS AMOUNT TO KMAP-3, LINE 13

* COST AND CHARGES PRIOR TO OCTOBER 1, 1990 ONLY

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Medicaid-3

SUPPLEMENTAL MEDICAID SCHEDULE

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR DUAL LICENSED BEDS

HOSPITAL _____

VENDOR # _____

PERIOD FROM _____ PERIOD TO _____

*1.	Dual-licensed NF-type Medicaid inpatient days	
2.	Dual-licensed SNF-type Medicaid inpatient days	
3.	Dual-licensed ICF-type Medicaid inpatient days	
*4.	Medicaid rate for dual-licensed NF bed services	
5.	Medicaid rate for dual-licensed SNF bed services	
6.	Medicaid rate for dual-licensed ICF bed services	
*7.	Medicaid payments for dual-licensed NF-type services (Line 1 x Line 4)	
8.	Medicaid payments for dual-licensed SNF-type services (Line 2 x Line 5)	
9.	Medicaid payments for dual-licensed ICF-type services (Line 3 x Line 6)	
10.	Total Medicaid payments for dual-licensed services (Line 7 + Line 8 + Line 9)	
11.	Total Medicaid dual licensed inpatient routine service cost	
12.	Medicaid dual licensed inpatient routine service cost net of dual-licensed payments (Line 11 – Line 10)	
13.	Indirect cost for ancillary services rendered to dual-licensed patients	
14.	Total unreimbursed Medicaid dual license inpatient service cost (Line 12 + Line 13)	

INSTRUCTIONS

Line #

1. From the Medicaid program's Paid Claims Listings
2. From the Medicaid Program's Paid Claims Listings
3. From the Medicaid Program's Paid Claims Listings
13. Transfer from Medicaid-2 Line 101, Column 12
14. Line 12 plus line 13.

* Effective for services provided after October 1, 1990

DISCLOSURE SECTION

SCHEDULE C

VENDOR NAME: ______________________ FYE ________

VENDOR NUMBER: ________

A: STATEMENT OF ORGANIZATIONS CONTRACTED WITH

NAME	TYPE OF BUSINESS	DATE OF CONTRACT		

B: PROTESTED AMOUNTS (NON-ALLOWABLE COST REPORT ITEMS)

ITEM	AMOUNT			SCHEDULE AND LINE		